MEETING SUMMARY

MISSOURI ADVISORY COUNCIL ON ALCOHOL AND DRUG ABUSE

April 4, 2007

Members Present:

John Harper	Daphne Walker-Thoth	Clif Johnson	Steve Doherty
Michael Dean	Keith Spare	Sylvia Persky	Cheryl Gardine
Becky Ehlers	Diana Harris	Kim Dude	Eleanor Ward
Robin Hammond	Ben Bruening	Stacy Braiuca	Dan Clark

Members Absent:

Sandy Hentges	Charles Megerman	Marilyn Gibson

Regional Advisory Council Chairpersons Present:

Mike Carter	Becky Markt	Tony Pickrell

Division/Department Staff:

Mark Stringer	Teresa Robbins	Terry Morris	Angie Stuckenschneider
Edwin Cooper	Joe Davidson	Joellyn Becker	Bianca Arrington-Madison
Chris Knigge	Kristi Scoville	Mary Henry	Jodi Haupt
Amanda Baker	Dirk Cable	Jonathan Smith	George Norman
Mark Shields	Kathleen Mims	Christina Oliver	

Guests:

Sular Gordon	Mike McLay	Alicia Ozenberger	Gerrit Den Hartog
Christine Owens	Ed Leoni	Andy Homer	

AGENDA	DISCUSSION/RECOMMENDATION	ACTION
Call to Order	Robin Hammond, SAC chair called the meeting to order and introductions were made. Daphne Walker-Thoth of Committed Caring Faith Communities in St. Louis was welcomed as a new member. Members reviewed minutes from the February 7 meeting. In doing so Chris Knigge pointed out a discrepancy where it was stated that the Southeast RAC had amended by-laws for themselves. RAC by-laws were amended to allow a vendor member to serve as co-chair. Clif motioned to approve the minutes with this correction, Kim Dude provided a second and motion carried.	
ADA Division Report	Mark Stringer reported to the SAC that staff changes for the Department of Mental Health include Dr. Joseph Parks appointment as the new CPS Director and Dr. Felix Vincenz as his Deputy Director and Chief Operating Officer. Mark feels confident that Dr. Parks will support a good working relationship between CPS and ADA. Reorganization at the Division of Alcohol and Drug Abuse includes Barbara Keehn's appointment as the new Deputy Director of ADA. She will continue to serve as the Eastern Region Administrator and divide herself between St. Louis and Jefferson City. In addition to her administrative strengths she is experienced in psychiatric services and has direct care experience as a Registered Nurse. This will prove invaluable as we pursue integrating physical, mental and substance abuse services for our clients. Marsha Buckner, the ADA Deputy Director of Administration is now the Director of Policy and Development an. She will be involved with Workforce Development and Outcomes Reporting. Laurie Epple, the ADA Director of Operations has become the Director of Administration. George Norman, Director of SATOP will now become the Director of Faith-based and Community Partnerships. Steve Deets, the Tobacco and Contracts Manager will now be the Director of the SATOP program. Nora Bock, with ADA Clinical Review and Compulsive Gambling will now become the Clinical Review Manager. Pat Veltrop, Billing Review Manager has become the manager of the Certification Section. Ultimately these changes will help us reach the goals of the strategic plan.	

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	Mark Stringer provided a legislative update regarding current budgetary issues facing ADA and advised that there would be no cuts planned at this time. The Access to Recovery grant will end this summer, and ADA has requested additional funding to support recovery services supported by this initiative. ADA has not been notified of the results of this funding request. Funding for the Opportunities to Succeed program, which serves Department of Corrections' offenders in St. Louis and Kansas City, has been reinstituted using about $430,000 from the Inmate Revolving Fund. The 2007 supplemental budget will include $613,000 for ADA and CPS providers to cover conversion to CIMOR costs. In 2008 there will be approximately another $700,000 allocated for this purpose. There was approval for a 3% provider Cost of Living adjustment as well as some Medicaid case load growth funds. In terms of legislation Senate Bill 577, Senator Shields' Medicaid reform bill, is generating the most interest. This bill will create coverage options for Medicaid recipients to include; 1) Managed Care Option (similar to MC+) 2) Administrative Services Organization – Difficult to define; they are not exactly managed care. They would provide some administrative services such as utilization management but wouldn't keep the profits. There may be incentives for them in some form for keeping costs down. 3) State Managed Option- which is similar to what we have now with established fees for service. The proposed Medicaid reform bill will include a Chronic Care Improvement Program, that Dr. Joe Parks, DMH Medical Director and Director of Comprehensive Psychiatric Services, has been working to develop. The original fear was that if a client chose one of the first 2 options that admissions under managed care would fall as they had in the 90's when MC+ was implemented. That affected not only the number of women's admissions but also children's. There are horror stories from that period of time with women being unable to access or remain in treatment. Senator Shields has listened to DMH concerns and retained the language	

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	carving out CSTAR programs and psychiatric services as separate from the managed care option. The proposed Medicaid reform does not appear to be a threat to DMH services. Additionally there is a new provision which requires Managed Care and ASO's to establish contracts with ADA and CPS providers in their areas. If passed this bill should eventually give our consumers better access to health care. Mark addressed the proposed privatization of three acute care facilities to include, Western Mo. Mental Health Center in Kansas City, Mid- Mo. Mental Health Center in Columbia, and St. Louis Metropolitan Psychiatric Center. There is current discussion about how to move more resources and money into community services for purposes of either diversion or better placement in the community after acute hospitalization. Some of this money would come to ADA to support substance abuse admissions to acute care psychiatric facilities. This may create some good opportunities for our Division when it occurs. ADA will be applying for the next round of Access To Recovery Grants with a potential of $7 million per year. The reapplication process will occur prior to the June 7th deadline and will include identification of ATR successes, ATR shortcomings and identification of our proposal to improve our ATR service delivery. ATR service delivery also fits with our ADA strategic service plan. The CIMOR information system continues to be a struggle. We have suspended some business rules in ADA to permit payment to providers. Some system obstacles are being reduced or eliminated and ADA providers are developing more expertise with utilization of this billing system. DMH technical resources has committed additional human resources to support the success of this information gathering and billing system. This new information system requires ADA providers to enter data in an accurate manner to support effective reimbursement. The data collection system does require a different set of technological skills by clinicians. Division staff will continue to provide technical assistance and support to provider staff to assist with effective billing practice.	
Strategic Planning	Mark Stringer noted that work has begun on a new Strategic Plan for ADA. This plan will include 5 major priorities for ADA. Mark will soon share the	Submit feedback to Mark Stringer regarding Strategic Planning either

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	draft in written form. Every aspect of the plan will addresses both treatment and prevention service. 1) Establish Centers of Excellence for addiction treatment and prevention. We will involve our stakeholders in defining what this means. Defining excellence in our programs will sustain us and give us credibility. Initially this will be voluntary for providers. Initially there will be language incorporated into our provider contracts and then later a core standard will be added within the ADA certification standards to identify a different tier of service. Some facets of this will be more costly to provide, however, our outcomes will demonstrate our excellence in service delivery, and generate support from our legislators. We would like to establish Centers of Excellence for every type of treatment and prevention service. In addition to existing treatment we are planning to create an Older Adult treatment tract, to encourage greater impact with this population. Co-occurring and trauma services will become an expectation and a basic competency in all agencies and we will have a way to pay for services to meet those needs. 2) Dock ADA Centers of Excellence with other large systems, for example a managed care plan, Dept. of Corrections, Children's Services Division, etc., to increase the impact we can have through collaboration. 3) Prove our value. We are competing on a lot of different fronts for funding. We have compelling figures to indicate the successes of our programs including measurable outcomes with the ATR programs. George Norman will now be working in this area as Director of Faith-Based and Community Partnerships and we will use the next round of Access To Recovery to refine our process in working with the faith community and other community partners. Evidence-based outcomes will demonstrate that this really does work. 4) Workforce Development- we intend to make a serious investment in developing and maintaining our workforce. We don't pay well enough to recruit and sustain quality staff in our facilities. We can establish a virtual training academy that includes not only Spring Training Institute but also training, that Missouri Institute of Mental Health (MIMH) has to offer, will include computer based learning and other venues for on-the-job training and mentoring. The DMH web directory,	now or at a later date. Robin Hammond specifically requested members submit their input regarding characteristics that would identify what a Center of Excellence would look like. Mark will soon supply a written copy of the draft and would much appreciate input. Comments may also be sent to Teresa Robbins or Robin Hammond to forward to Mark.

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	Network of Care, has great potential in making on-line training available to our providers. We intend to do whatever it takes to get our existing workforce up to where we need it to be and attract new people to the field. We plan to work aggressively as a Division with colleges, universities, and professional schools to develop curricula, internships, and practicum placements. This approach ties in with Dr. Edward Leoni's proposal for a prevention credential. The Access to Recovery initiative has encouraged training efforts with encouragement of professional development. 5) Establishing treatment on demand. Mark will evaluate his own success by how close we come to achieving this goal. Research shows that people who call for help and don't get it within 48 hours typically don't make it to treatment at all and that is a tragedy. Figures are floating around the legislature estimating savings to the State as a result of Missourians receiving treatment. Every discipline claims to have these figures. ADA does have good national data to support our efforts; however, this data is not yet available at the state level. Treatment in Missouri is a good bargain, even if someone doesn't "get it" the first time. Mark quoted Dr. David Smith, founder of the Haight Ashbury Free Clinic "Treatment effects are cumulative", for some it is a lifelong process. It is hopeful that the faith community may fill this void until treatment on demand is available, by early identification of the need for treatment and by provision of "pre-treatment" services. Mark asked the SAC for feedback regarding the ADA Strategic Plan. SAC members suggested the use of consumer advocates as part of Centers of Excellence, in workforce development, and possibly even requiring consumer members on their provider Board of Directors. Perhaps the final strategic plan document could include intentions to involve consumers and consumer family members, as well as emphasizing intense collaboration with other agencies. Partnership and collaboration must extend beyond just linking services with other agencies; we need to have DMH/ADA services available when other agencies refer clients to us. Mark will be presenting the Strategic Plan along with the Department of	

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	Mental Health's Strategic Plan to the Mental Health Commission in May of this year. The plan's effective date will be July 1st, but we are not waiting to put some of the factors in place. Initially these changes will need to happen with existing resources. These same themes are reflected in the Transformation Initiative Workgroup meetings, according to Gerrit Den Hartog. We will expect all providers to demonstrate core competence in working with co-occurring disorders and cultural competency with the population that they serve. Stacey Braiuca noted the Native- American population may be invisible and that we need to be responsive to this issue and to know where to refer native Americans for culturally responsive services.	
Proposed Prevention Credential	Ed Leoni addressed the group regarding the proposed Prevention Professional Credential. The prevention discipline is an extremely eclectic group of professionals. Credentialing would give the profession credibility and that everyone speaks a common language with recognition of science-based principles of effective prevention practice. Professional prevention teams have identified eight core competencies that would need to be demonstrated within the framework of the Prevention Professional Credentialing process. The development team has identified three levels of prevention professional competency. SAMHSA has made prevention training available on-line to support prevention professional development. The training is free unless you request CEU's and then there is a nominal fee. Completion of the SAMHSA course would be prepare a prevention professional to be qualified for the first level of the credentialing process. The second level would require completion of 400 clock hours of internship (fieldwork). All of the core competencies would be practiced along with demonstrated skills and college credits, as obtained in a practicum, or under supervision. The criterion for the Third Level credential includes the provision of grandfathering in professionals who have been in the field for a long time. They would submit a portfolio of their experience for the credentialing body to determine their qualified status. Once deemed qualified, they would be able to serve as a prevention mentor and supervisor. The Fourth Level would be the national level which would involve reciprocity among participating state entities. The credentialing process will eventually be incorporated into prevention	

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	contract requirements. It would also become a requirement for a provider to have at least an identified percentage of their prevention staff credentialed to be considered a Center of Excellence. The final outline is not yet completed for this credential. Anyone who would like a head start on obtaining this credential can visit the SAMHSA site and start working on the online course. A question was posed regarding having to complete fieldwork on all eight core competencies as part of Level Two. This is a starting point and is not "set in stone". The amount of 400 required hours would probably not change, but it might be possible to pick and choose some of the eight core competencies as a focus rather than demonstrate them all in full.	
Workgroup Reports **COSIG Progress Report**	**Prevention Workgroup:** Participants discussed what they are seeing in the regions. The regions are still trying to figure out how the new reporting guidelines work so that was discussed. They spent some time talking about National Guard technical assistance, mini-grants and the SPF - SIG process. Robin asked if an hour was adequate for the workgroups. Ben Bruening felt that now that the workgroups are more developed that they might need more time. **Treatment Workgroup:** Access To Recovery and recovery support services was again the focus of the discussion. Mark Shields ADA ATR representative assisted the group with technical assistance relating to their ATR questions. The top tier services were recommended to maintain, while eliminating or cutting back on some of the other services that the providers could offer themselves. Clif Johnson will submit the list of recommended services with his committee report. Also discussed was the viability of requesting that Area Treatment Coordinators attend RAC meetings. Another topic of discussion was the issue of clients in residential treatment who are prescribed methadone. There has been some question as to whether the DEA has jurisdiction over the treatment facility if there is methadone present. It seems there is a misunderstanding regarding the rules of storing dispensed methadone in our facilities. There is a lot of uncertainty and stigma at play with providers who aren't accustomed to dealing with methadone.	The SAC agenda will contain additional time for committee work. The Treatment Committee recommended that the most important services to keep with ATR are the ones the treatment providers are incapable of providing themselves. It was recommended by this committee that Area Treatment Coordinators be encouraged to attend some or all of RAC meetings. Recommended scholarships (from RAC/SAC) for provider staff to attend methadone training to learn the protocols involved in having access to this treatment during residential care in a different treatment facility.

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	National methadone conferences or SAMHSA could be used to acquaint and train staff in the measures and precautions that should be taken with methadone clients. Increasingly this is becoming a contentious issue with families whose loved ones were denied treatment due to methadone use. Dr. Andy Homer, COSIG Project Director, noted that we are in the fourth year of a five year grant. The Co-Occurring State Infrastructure Grant has served to increase the Division's capacity to serve individuals with co-occurring mental disorders and substance use disorders. Historically we have had extremely poor outcomes for clients with co-occurring disorders, very likely because we lack the expertise to treat both In the first stage of the grant we provided training, developed screening and assessment instruments, and developed treatment models. We did not find significant differences between the rural and urban sites except fewer psychiatrists in the rural areas. Dr. Homer was initially discouraged in viewing the COSIG results from 2004 to 2006. He has since spoken with other COSIG states and they report similar results. When we labeled the project a "pilot" people saw it differently than a long- term commitment and were reluctant to make major changes and investments in staff and training. In phase two of COSIG our goal is to implement some permanent, sustainable long term changes in our treatment practices. Other goals are to develop certification standards to support COSIG, establish a counseling credentialing process, and implement standardized statewide screening and assessment for co-occurring disorders. For counselor credentialing Andy's recommendation is to use the ICRC which is in the process of being adopted nationally and offers credentialing of mental health and substance abuse counselors. We want to establish a structure in Phase two which supports change and moves us towards evidence-based practices. All treatment programs may not be able to offer co-occurring services; however, all should enhance their ability to handle co-occurring issues, with effective screening and referral process. To support co-occurring treatment practice, ADA will provide technical	Stacy Braiuca will represent the SAC on the COSIG Steering Committee. COSIG was specifically looking for a consumer member to provide input from a consumer's vantage point.

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MSACCB Report	assistance to agencies in the areas of quality improvement and staff education. We will also need to develop an effective screening instrument for adolescents, we are uncertain if the current screening instrument developed for adults would work for adolescents. Mark Stringer reported that the House version of 877 has $1 million (part general revenue and part federal) for co-occurring services for adolescents. On the CPS side 90% of children treated who have serious emotional disturbances at age 15 will develop a substance abuse problem by age 25. This is the highest risk group and it hasn't been addressed at all. Stephen Doherty provided the Missouri Substance Abuse Counselor' Certification Board, Inc. report to the SAC. The Certification Board recently administered the written tests for various credentials and had one of the highest pass rates in a long time. He reported a total of 85% of the 26 people taking the test passed. It's too early to say for certain if the supervisory training has had positive impact on those taking the test but that is a possibility. He pointed out the excellent value of their trainings for counselors and prospective counselors at a cost of $25 per training with corresponding CEU credit. The Certification Board is planning a name change that would be more inclusive of the various entities they represent including criminal justice professionals. A new name has been proposed but hasn't yet been locked in. The Certification Board currently has a position open for a Certified Prevention Specialist. Supervision trainings are being offered. The cost is $75 for 3 days, and classes always fill up when announced. There is a revised supervision manual that will be available through the Certification Board or at the trainings for $30, which is less than the cost of the original.	

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Membership Report	All members received an updated membership chart for SAC. We have 19 SAC members, with 2 openings in Eastern region, one of which may be filled by Diana Harris June 30th when she completes her term as RAC chair. We would like a consumer to fill the remaining slot. There is one opening in the Southwest Region for a consumer. The Southeast Region has 3 openings for consumer members. Teresa has corresponded with one potential recruit from that area. We have received confirmation that we have a room reserved for lunch on Thursday of the Spring Training Institute to meet with Carol Coley, our Federal Block Grant Specialist, for technical assistance. This should give the SAC a better understanding of funding coming into Division of Alcohol & Drug Abuse. More information on this will be forthcoming.	
Adjournment	A card was circulated for Rhonda Wilkes, past chairperson of the SAC. We will also be giving her an engraved acrylic award in appreciation of her service. The next SAC meeting will be held June 6th. Diana Harris made a motion to adjourn the meeting; Stacy Braiuca provided a second. Motion carried and the meeting was adjourned.	